Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Urgent Orthopedic Specialists

Respondent Name
Bitco General Insurance Corporation

MFDR Tracking Number
M4-15-0491-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position statement from the requestor was not included in the submitted documentation.

Amount in Dispute: $170.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs from Corvel. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson, PO Box 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2014	Office Visit and Work Status Report	$170.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the requirements for submitting medical bills.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B20 – Procedure/service was partially or fully furnished by another provider.

Issues

1. Were the disputed services provided by the billing health care provider as required in 28 Texas Administrative Code §133.10?

Findings

1. The insurance carrier denied the billed services, stating that the "procedure/service was partially or fully furnished by another provider. Review of the medical documentation finds that the rendering provider for the services in question was Bryan Allen, FNP, BC.

   28 Texas Administrative Code §133.10 (f)(1) states, "The following data content or data elements are required for **a complete professional or noninstitutional medical bill** related to Texas workers' compensation health care: (U) **rendering provider's state license number** (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); (V) **rendering provider's NPI number** (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number" [emphasis added].

   Review of the submitted documentation finds that the billing provider listed in CMS-1500/field 33 is Urgent Orthopedic Specialists. As the rendering provider is different from the billing provider, the rendering provider's state license number is required in field 24j (shaded portion). No license number was listed in this section. For the same reason, the rendering provider's NPI number is required in field 24j (unshaded portion). The NPI registry found at https://nppes.cms.hhs.gov provides NPI number 1578564746. This is not the number listed in the required field on the bill provided. Therefore, the insurance carrier's denial reason is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 27, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.